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This is to be the first of two technical reports sharing the same title. It describes the testing procedures used by the Educational Diagnostic and Planning Center, outlining the manner of data gathering from objective, standardized instruments and other sources. It also describes the collation of data into meaningful descriptive summaries. The appendices include a list of the evaluation instruments and a detailed case study illustrating the testing procedures. (Author/KP)

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TECHNICAL REPORT NO. 7

DIAGNOSTIC PROCEDURES AND THEIR INCORPORATION IN THE PLANNING OF INDIVIDUAL REMEDIAL PROGRAMS

Part I

by

Theodore L. B. Gloeckler

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INTRODUCTION

Two technical reports, numbers seven and eight, share the same title and describe a continuing process. Each, however, is concerned with essentially different aspects of that process. The first report describes the testing procedures used by the Educational Diagnostic and Planning Center. It outlines the manner of data gathering from objective, standardized instruments and from other sources. It also describes the collation of these data into meaningful descriptive summaries. This report includes appendicies with a list of the evaluation instruments used at the Center and a detailed case study illustrating the testing procedures.

Technical Report #8 is concerned with the use of the evaluation results in the planning of individualized programs of remediation. It describes the process of translating diagnostic data into specific teaching goals and the methods employed in achieving these ends. To provide the needed continuity, the case study which is begun in Technical Report # 7, is continued here.

It must be recognized and emphasized that the Center makes no claim to the originality of the work described. The report simply outlines the operating procedures unique to the Center but the programs, ideas, suggestions, and procedures for remediation may have been developed by other professionals in the field and presented in textbooks, manuals, and through individual or group consultation.

In the same light, this writer recognizes the contributions of the members of the staff of the Educational Diagnostic and Planning Center and the consultants to the Center. These reports reflect their professional competencies in the work of the Center and their specific suggestions in the preparation of the manuscripts.

T. Gloeckler

Purpose of Testing

In general, it is the purpose of the evaluation process to examine the data relevant to the problems manifested in the child referred to the Educational Diagnostic and Planning Center. Testing assesses intellectual, sensory, social, emotional, language, motor, and academic functioning. Provision is made to incorporate other data such as medical information and observation reports from professional sources in the overall pattern of evaluation results. Procedures have been developed to allow for complete and effective diagnosis with an economy of time invested.

Qualifications of the Testers

All psychological testing is done by competent individuals certified by the Department of Education of the State of Wyoming as Psychological Technicians, by the full-time psychologist (with doctorate), or by the part-time psychologist assigned to the staff. Motor testing is done by an education specialist with appropriate training and background. Speech and hearing evaluation is performed by a therapist qualified in this area. Academic testing is usually done by the educational specialists on the staff who will eventually write and implement the remedial program.

Tests Available at the Center

Appendix B lists the instruments available at the Center. It should be noted that not all these tests are used regularly and that a few have been found to be inappropriate or ineffective and their use has been discontinued.

Confidentiality of Results

Ut most care has been taken to protect the rights of both child and parents. A permission form must be signed by the parents before the Center will initiate any work and both parents are informed about the testing procedures. They are aware that the results will be presented to the teacher and principal of the school from which the child has been referred and that no other individual or agency outside the Center staff will be privy to these data.

No information is released from the files without a written request from the parents through the soliciting agency and, in return, no data are gathered from other sources without the parents' signed authorization. Al files are stamped "Confidential" and are kept in locked cabinets.

Written interpretations are made for most testing and this information, rather than specific scores and protocols, is revealed to school personnel and parents. The parents receive this information at a second conference following the staffing of the case but prior to the initiation of any work with the child.

Although testing results (unidentified in relation to individual children) may be used for analysis and clinical research, no testing is done for this specific purpose. Similarly, no programs are established for reasons of research or experimentation although the existing programs may be examined to determine their effectiveness and to provide data for future planning.

Outline of the Center's Operation

Presented here is a list of the steps in the operation of the Center to give the reader an overview for understanding subsequently presented material in context.

1. Referral to the Center by the classroom teacher and principal. The referral form and the child's cumulative guidance folder are submitted at this time.

2. Screening - the Center's decision to accept or reject the case.

3. Parent Conference - orientation on the role and objectives of the Center in their work with the child, his family, and his school, solicitation of information of the developmental history form by the Center nurse, and, frequently, a Vineland Social Maturity Scale solicited by a counselor of the Center social worker.

4. Securing data from other agencies.

5. Testing the child.

6. Possible classroom observation with added reports from a conference with the teacher.

7. Amalgamation and presentation of accumulated data at the staffing conference.

8. Additional academic testing if needed.

9. Second parent conference to interpret results and outline the general plans for aid.

10. Planning and implementation of the specific program.

11. Continuous evaluation throughout the program.

12. Termination of direct services at the completion of the program.

13. Continuing periodic check on the child's progress.

Sources of Information

Extensive data are collected for eventual presentation at the staffing conference. Areas of both strength and weakness are important. Therefore, it must be recognized that, whereas some exploration will result in no evidence of aberations, such information is cogent in the comprehensive view of the child, his development, and his functioning.

Data are collected from:

1. A Developmental History: Part of this form is sent to the parents prior to the initial interview. They can then secure ontological data from baby books and recollection at their leisure, not under the press of interview. They return this form to the Center nurse who meets with both parents, pursues pertinent areas, and obtains clarifications. At this time a counselor or the Center social worker may de a Vineland Social Maturity Scale.

2. A Family Interview Form: This form lists objective data on family relationships, ages, occupations, etc. This is completed by the Center nurse at the first interview.

3. Cumulative Guidance Folder: The cumulative guidance folder is sent by the school with the initial referral form and pertinent parts are photographically reproduced for the Center's file. Such materials include grades, teachers' comments, anecdotal material, testing results, health information, absences and other special information which may have been placed there.

4. Referral Form: This, prepared by the classroom teacher and the principal, with the help of a Center staff member if they so wish, outlines the presenting problems and current school functioning of the child.

5. Medical Records: The family doctor is notified of the referral and, with a signed release form from the parents, is requested to furnish pertinent data.

6. School Records: These are solicited from schools in which the child was formerly enrolled outside the Cheyenne system.

7. Records from Other Agencies: Reports are solicited from other agencies which may have been previously concerned with the family or which may be currently working with them. Such agencies might include Southeast Wyoming Mental Health Center, Welfare, Crippled Children, etc.

8. Report of Classroom Observation: This is made by a Center staff member who visits the school prior to the staffing conference.

9. Testing Reports from the Diagnostic Workup.

It can be seen that the multi-discipline approach is not limited to the examination of presented data or to the development of the remedial program. It is also important in the area of data gathering. The classroom teacher and the principal provide the initial information. The Center nurse completes the developmental history form and maintains contact with members of the medical profession. The social worker completes the Vineland Social Maturity Scale and maintains contact with other social agencies. The Center education specialist does classroom observation and provides some of the educational testing. The counselor confers with the psychological technician on the interpretation of test results and may meet with the teacher to secure additional information on the child's classroom behavior. The speech and hearing therapist is responsible for providing evaluation in her area.

Diagnostic Procedures

Tests Administered:

Bateman (1964) recognizes the difference in the research situation in which a standard battery is employed and the clinical setting in which instruments are indivudally chosen for the subject. The Center used the latter approach. No basic battery has been developed, although each child referred does receive an individual test of intelligence, and a speech and hearing evaluation. Instruments are available for assessing the areas of intelligence, sensory functioning, perception, social and emotional development, spoken and written language, spelling, reading, motor development, etc. Tests are selected by the psychological technician with the aid of the staff members based on presenting problems at the time of referral. The planned evaluation may then be altered to follow promising leads as the evaluation progresses.

There is a difference in the amount of data solicited from outside sources and that sought directly from the client. Mass accumulation of information from the school and other agencies does not have the impact on the pupil as does subjecting him to extensive testing. Yet some kind of inverse ratio does exist between the two since the staff, in most instances, places more weight on the reports of the examiners who were directly involved with the child. The recency of these data also contribute to the magnitude of their relative importance.

To avoid "overtest", results of examinations given by competent psychometrists within a previous, reasonable time limit are accepted. This practice also avoids the duplication of services as well as the problem of performance carry-over. Similarly where it may be decided to add a projective technique to the battery because of the child's behavior on the earlier-administered instruments, other planned testing may be omitted because of earlier performance.

Goals of Testing:

In determining the direction and extent of the evaluation, consideration must be given to the goals and purposes of the testing in a more specific way than outlines in the opening paragraphs of this paper. If one wishes simply to label a child, a single score on an intelligence test is sufficient. Other instruments may be fine for catagorizing children. However, neither of these goals is acceptable to the professional staff. Since the organization is the EDUCATIONAL Diagnostic and Planning Center, the end toward which evaluation is directed is that of providing specific aids in relation to the poor academic or social functioning of the child in the school. Therefore, we tend to follow Bateman's (1965) direction that "when the primary purpose of diagnosis is to plan remedial education procedures, tests should be employed which examine directly those factors which are remediable by known methods."

For example, tests such as those of reading readiness used in the elementary schools are not designed as sophisticated instruments for diagnosis of reading problems but are used to determine general ability in a few areas of reading. Usually these tests are used as a basis for grouping children for further instruction. Although this process is of highly questionable merit, it is beyond the scope of this report to examine these aspects. The example

is made only to indicate that such testing is economical in relation to the purpose for which the results are used. The subsequent teaching to groups of children without fully considering individual differences in basic reading skills and learning processes might make other, more definitve testing, a waste of time.

On the other hand, where serious problems in learning exist and individualized instruction becomes necessary, testing must uncover the underlying deficits whether they are in the area of perception, processing, integration, retention, or production of information.

In the Center much work is done with children with learning disorders. The Center staff does not challenge Myklebust's (1968) claim of a neurogenetic basis for such problems but only rarely recommends a complete neurological examination (at the expense of the parents). The results would little affect the remedial procedures. As Kirk (1966) states, "Knowing whether a reading disability stems from lack of development or from injury to the angular gyrus, or some other area, does not, in most instances, alter the remedial process." However, knowing if the basis for a reading problem results from a deficit in visual acuity or from visual perception does have meaning in terms of the program developed.

Although it is important to find levels of functioning, essentially the diagnosis is directed toward delineation of the specific deficits which underly the academic problems as well as those channels which remain intact and are the basis for the child's successes. In this investigation economy is needed not only in the tests administered but in the extent of interpretation.

Test Interpretation:

When all the instruments have been administered by the psychometrist or psychologist and the academic tests by the education specialist, these examiners collate the resulting data in written form for presentation at the staffing conference. Reliance is placed on the professional capabilities of these experienced people so that, whereas all protocols and scores are immediately available upon request, they are not routinely displayed at the staffing.

These examiners are not unaware of the additional data which have been collected from other sources, the home, the school, the physician, and other agencies, and each of these reports will be viewed with the test data to provide a more composite picture of the child. This also precludes simple catagorization or stereotyping of the client on the basis of test scores or limited information.

In this process of moving away from general catagorization and toward an understanding of the specific tasks underlying behavior, or, as Bateman (1964) would call it, "determining relevant correlates of the disability", test scores in terms of intelligence quotients, percentiles, grade scores, etc., do become devaluated, although certainly not ignored, in the heirarch of importance. Results of subtests and individual items are cross validated among the instruments to support emerging styles of behavior. The examiner looks for consistencies across test parameters. The word "consistencies" is preferred to "patterns" since the latter might become confused with the practice of relying soley on intratest pattern analysis as proposed by both Wechsler (1958) and Rappaport, et al (1945).

Capobianco (1964) suggests that this method of looking at tests "is only as proficient as the clinician who employs it". And certainly the process is not without peril. The examiner must be aware of many possible pitfalls before he presents a final interpretation of his findings.

He must be aware that the tests selected might possibly influence his interpretation unduly. For example, if the child is suspected of having emotional problems and several instruments are added to his individual battery to assess this area, the resulting data, preponderant in comparison to those from other areas, may seem to confirm the hypothesis of emotional involvement. Therefore, the tester must not permit the quantity of data to disproportionately influence the qualitative evaluation of the true extent of affective influences in overall functioning.

The examiner will also be faced with conflicting data from the several tests and he must determine the extent to which these must be reconcilliated. The possibilities of these differences accruing by chance, differences in standardization groups, errors of measurement, the testing situation, etc. need consideration. However, he must not pass all differences off to these causes; some discrepancies might push him to further fruitful investigations. For example, differences in vocabulary scores might be puzzling to the examiner until he looks at how the information was solicited of each of the instruments. If the WISC score, on which words are presented orally, differs from the Gates-MacGinitie score, on which they are presented visually, he may have discovered a more basic kind of problem than one of limited vocabulary.

Certainly the examiner must be aware of the many studies, including those of validity and reliability, for each of the tests he employs. He should also be aware of his own skill in administering each of these and, if possible, of his own tendency to see particular kinds of problems in preference to others. In this regard, the multi-discipline approach used by the Center is beneficial to the staff members. Testers are more aware of the varieties of problems as well as of the remedial procedures available than if he were simply concerned with his own field.

One of the major tests so "taken apart" for analysis and comparison with other instruments is the Wechsler Intelligence Scale for Children. The work of Lutey (1966) and of Glasser and Zimmerman (1967) have been influential in guiding the examiners in this procedure. These and other studies such as those referred to by Anastasi (1968) have made the testers aware of the need to be concerned with the reliabilities of the WISC subtests and the tentativeness of some of the popular interpretations which are given. He must be aware of the sex, age, and socio-economic status of the individual. Then too, he must be concerned with how much difference in subtest scores is necessary to indicate concern. To paraphrase the semanticists: How much of a difference does it take to make a difference? This not always an easy decision for as Glasser and Zimmerman point out, "...very large differences <u>can</u> occur by chance..., while very small differences can give a most valuable clue as to real variations in ability."

How might an investigator proceed to examine test data in this manner? The following is an example of the lines of thinking a tester might follow prior to writing his interpretations.

TOMMY
C.A.: 12-3
Test: Wechsler Intelligence Scale for Children

Verbal I.Q.: 90 Performance I.Q.: 111 Full Scale I.Q.: 100

Subtest Scatter:

Information	9	Picture Completion	11
Comprehension	10	Picture Arrangement	9
Arithmetic	6	Block Design	12
Similarities	9	Object Assembly	14
Vocabulary	11	Coding	12
Digit Span	5	Mazes	Not given

As the tester proceeds with his interpretation he may feel called upon to consider the low subtest score on arithmetic. He might ask:

In relation to the fact that the subject is male, does the score on this subtest indicate he is poor in computational skills?

How does this score compare with (a) his school grades in math, (b) the Iowa Tests of Basic Skills given regularly in the schools, and (c) the results of the Wide Range Achievement Tests?

If these other measures indicate relative intactness of arithmetic skills, do we look on this low score as indicative of anxiety?

If so, what kind of anxiety? - test specific? - pervasive in general functioning? - relative to the specific subject of math?

Are there particular ages at which this test might be more sensitive to anxiety than at other ages?

Is this hypothesis supported by other signs of anxiety such as (a) teacher reports of classroom behavior, (b) results of projective techniques, (c) the examiner's subjective evaluation of behaviors manifested in the test situation, or (d) other indications in the WISC itself, such as the pattern of incorrect responses prior to reaching the cut-off points in the subtests or the scores on the other two elements of the so-called "anxiety triad"?

Does the fact that the third subtest of this triad, Coding, does not have a score which correlates well with the other two interfere with the anxiety hypothesis?

If so, then do we look at the Digit Span as an indication of an auditory-memory deficit which might influence the results of the Arithmetic subtest which is presented as a listening and oral response task?

Have we been concerned with the difference between the Verbal and Performance I.Q. scores? Do the direction and spread of these suggest a learning disorder rather than an anxiety problem?

What other evidence is there which might support the possibility of a learning disorder in the auditory memory area? Should he look at the auditory-vocal sequential part of the Illinois Test of Psycholinguistic Abilities?

But is this subtest, similar to the other two on the WISC, also subject to the influences of anxiety?

Can we look to other tasks which may have memory and sequence factors? - the Information subtest on the WISC? - the oral vocabulary section of the Gates McKillop Reading Diagnostic Test? - the general orientation tests used by the Center in which the subject is asked for such seemingly routine information as the days of the week, the months of the year, and how to tell time? - the child's spelling with particular emphasis of orally presented tests?

Have we looked at both the Arithmetic and Digit Span subtests in relation to the child's sex, age, ethnic, social, and cultural background?

And what about the test situation itself? If the test was given in the school with bells ringing, classes passing in the hall, etc., could these be factors in depressed performance particularly if the child tended to demonstrate auditory distractibility?

Of course it must be decided if it is warranted to attend to this degree to one or two subtest scores, and, of course, each one need not necessarily receive such attention. This subtest score on Arithmetic might fit neatly into the child's presenting problems and thus be accepted in this context, - as relecting an already-recognized deficit. The example is presented to indicate that in some cases more condieration must be given to the results.

The interpretation, then, becomes one of intertest evaluation and it is hoped that increased reliability occurs. This should not be taken for granted, however, since it is not inconceivable that an error in interpretation might be magnified by this process. It is possible to build a great house of cards on a foundation of test scores alone which, when checked against a careful observation of the behavior of the child himself, comes tumbling down. "Blind" interprestation of protocols may be a challenging academic exercise, it can be a dangerous game played with questionable profssionalism.

Part of the examiner's consideration in both interpretation and presentation of result, therefore, is his description of the child and the testing situation. Rapport, response patterns, indicies of anxiety, test behaviors, etc. are given and the examiner is expected to be sufficiently secure to reject the validity of results should he assume these or other factors place them in question.

Staffing Conference:

The staffing conference is that point at which the thrust of effort changes from one of diagnosis to one of remediation. Representatives of each discipline are represented and each individual who has worked with the child presents a report. The teacher and principal from the school are present and not infrequently is a school counselor, a physician or a representative from another agencies invited to attend.

It is the deliberations of the staff following the reports which culminate in a list of recommendations for subsequent action. Additional information may be requested prior to a restaffing. The Center may decide to refer the parents to a more appropriate agency. It may be decided that the Center will take an active role in remediation and offer an individualized program for the child and his family. Staff members are assigned to design the program based on the evaluation results and the recommendations of the staff at the conference. The program may be academic, counseling, motor, water, speech therapy, etc. The parents may be requested to meet for individual counseling or assigned to an evening group counseling situation. Any combination of these may be recommended.

Following this staffing the parents are seen again so these suggestions and evaluation results might be reviewed. Their support and cooperation are solicited. Then the program is planned and the work begins.

Throughout the entire process the child remains central. Center testing never results in venalistic labels. Strengths and weaknesses are noted but nowhere in the reports is the child referred to as "emotionally disturbed," "brain damaged", etc. Whereas such labels may not be inappropriately assigned, they offer only the grossest direction toward remediation and, on the other hand, may result in the school's stereotyping the child and thus the label becomes an additional problem to him. The program of remediation is, instead, based on the child's unique pattern of strengths and weaknesses. It is a practical, and not a romantic, consideration that the staff members maintain the attitude that they work, not with a problem child, but with a child with problems.

Continuous Evaluation:

The evaluation process does not terminate at the staffing conference. Often some specific diagnostic test is administered following the staffing by the person who has been assigned to work with the child. In this way the clinician can see the child's functioning, observe how he attacks problems, and begin to establish rapport. This experience also helps the education specialist in her program planning.

The program which is then planned includes provision for continued, periodic evaluation as well as for diagnostic teaching to continually define the effectiveness of the program.

Later as the work progresses, the need for further testing may become necessary to evaluate the progress of the child. The psychometrist or the education specialist may provide this needed service. In a few cases testing might not have been possible prior to the initiation of a program and the eventual successful administration of a test becomes an achievement in itself regardless of the score. One kindergarten girl who demonstrated behaviors similar to those of infantile autism and who was able to be tested only after a year of intensified individual work, is an example of such a situation.

A Case Study:

Appendix A contains a case study from the files of the Center. Only the diagnostic portion of the case is presented here. The remainder of it will be used in Technical Report No. 8, illustrating the incorporation of such evaluation information in the planning of the remedial program.

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APPENDIX A

A Case Study:

Test Results and the Examiner's Report

Although identifying data have been disguised or omitted, the following is an actual case in the file of the Educational Diagnostic and Planning Center. It should be noted that some material has been condensed and that only those data relevant to the purpose of this report remain.

The testing and reports are the work of the Center Psychological Technician, Mrs. Patricia Fleming.

BILLY S.

Presenting Information:

Billy was referred to the Diagnostic Center from an elementary school where he was enrolled in the second grade, repeating that grade. His chronological age at the time of referral was 9-2.

On the Initial Referral Form the school presented the following reasons for the referral: "This child has made little progress in reading. His intelligence test shows he should be doing better work. He cannot remember phonics and seems to read by just telling about the pictures in the book."

Center Testing - Results:

Vision Screening: from family physician
Left eye: 20/20 Right eye: 20/20

Hearing: (Tester: Mrs. Nina Smith, Center Speech and Hearing Therapist) Puretone evaluation of hearing acuity by air conduction revealed normal functioning. Speech reception threshold was 10db for both ears.

Speech: Billy does have a few misarticulations of phonemes (see test for details). He should be referred to the speech therapist by his teacher if this has not already been done.

P.B.K. word test reveals discrimination of phonemes is adequate.

Developmental History: Information on the family has been omitted here. The developmental history seems unremarkable. However, some school difficulties have been found. Billy began school in first grade (with no kindergarten) in another state. In the middle of this first year the family moved to Wyoming where he completed first grade. He was retained. During the summer following this retention the family moved to a new home and Billy was enrolled in a new school to begin second grade. After receiving poor grades and being unsuccessful in learning to read by the predominantly phonics approach advocated by the teacher, he was, at her recommendation, again retained. The referral to the Center came during his second time in second grade when there seemed to be no progress.

Wechsler Intelligence Scale for Children: Verbal I.Q. 91
Performance I.Q. 96
Full Scale I.Q. 93

Information	10	Picture Completion	10
Comprehension	7	Picture Arrangement	12
Arithmetic	10	Block Design	11
Similarities	9	Object Assembly	7
Vocabulary	10	Coding	6
Digit Span	6	Mazes	10

Picture Story Language Test:

	Age Equivalent		Percentile	
	Written	Oral	Written	Oral
Productivity				
Total Words	7	7	2	5
Total Sentences	7	7	5	15
Words Per Sentence	7	7	2	5
Syntax	7		10	
Abstract-Concrete	7	7	15-20	15-20

Peabody Picture Vocabulary:

M. A.	8-9
I.Q.	98
%	47

Gates McKellop Reading Diagnostic Test:

I. Oral Reading 1.8
Ommissions 27
Mispronunciations 28
(19 errors under wrong in several parts category)

II. Words: Flash presentation 1.75

III. Words: Untimed presentations 2.25

IV. Phrases Flash presentation 2.1

V. Knowledge of Word Parts
Recognizing and blending common word parts (none correct) 2.0
Letter Sounds 1.7-1.9
Naming capital letters (missed one)
Naming lower case letters. Perfect score.

VI. Recognizing Visual Form of Sounds

Nonsense Words	1.7-1.9
Initial Letters	2.3-2.6
Final Letters	1.7-1.9
Vowels	1.7-1;9

VII. Auditory Blending

VIII. Supplementary Tests	3.0-3.2
Spelling	
Oral Vocabulary	2.4
Syllabication	5.2
Auditory Discrimination	1.0-1.6

Illinois Test of Psycholinguistic Abilities:

	Language Age
Decoding	
Auditory	5-11
Vocal	6-7
Association	
Auditory Vocal	6-10
Visual Motor	7-10
Encoding	
Vocal	6-7
Motor	5-10
Automatic	
Auditory Vocal	6-10
Sequential	
Auditory Vocal	6-3
Visual Motor	4-10

Frostig Test of Visual Perception:

	Perceptual Age
I. Eye-Motor Coordination	7-9
II. Figure Ground	4-6
III. Form Constancy	6-9
IV. Position in Space	8-9 (Ceiling)
V. Spatial Relations	8-3 (Ceiling)

Wide Range Achievement Test:

Arithmetic Grade 2.6

Bender Gestalt:

Visual Perceptual Level of average seven year old boy.

Draw-A-Family: 10-25-68

Channel Deficit:

When material was presented orally and response was visual, 6 digits were repeated; all others were 5 digits. Not significant.

Gates Primary Reading Test:

Reading Grade 2.2

Sentence Completion: Results not included here.

Thematic Apperception Test: Responses not included here.

Examiner's Report

Billy was referred for complete evaluation by his reading teacher. The principal reason for referral was a reading problem. He is described by one teacher as sweet, polite and well behaved and the reading teacher as aggressive, a show-off. The Metropolitan Achievement Test administered April, 1968 scores:

Reading	1.9	8%
Arithmetic	3.2	78%

The final report card in first grade shows: F's in Language Arts, Reading, Science, and Social Studies. All other grades were 4's.

Billy was a polite boy of below average physical development. He was compliant; did everything asked, but good rapport was not established easily. He appeared restricted and does not have the spontaneity expected of a nine year old boy. He showed little enthusiasm until the final day of testing when he experienced real success in one subtest. He tries very hard to please.

Billy appears to have a poor self concept. He has ambivalent feelings regarding his family whom he views as sometimes nice and sometimes mean. The other children call him flunker and his real lack of school achievements has contributed to his poor self concept. There were indications of feelings of hostility and desire for aggression. The only indications of overt aggression were noted in the reading class of the previous year.

An evaluation of Billy's strengths and weaknesses does not present clear cut areas of specific strengths and weaknesses, although he shows many areas which indicate a need for remediation.

The WISC administered 5-16 placed him in the Average Range of mental ability when compared to others his age in the general population. There was little difference between the Verbal I.Q. (91) and the Performance I.Q. (96), Full Scale I.Q. (93). There was scatter in the subtests however. Although Billy shows average fund of general information and vocabulary skills, his general comprehension was below average. His strength in vocabulary was also indicated in the Gates McKillop and the Peabody Picture Vocabulary Test.

In the visual perceptual area, Billy earned a perceptual age of 4 years 6 months in Figure Ground subtest of the Frostig Test of Visual Perception. Below average scores were also earned in Eye Motor coordination and Form Constancy. In the Bender Gestalt, he earned a score comparable to that of the average 7 year old boy. The Coding subtest of the WISC which demands eye-motor coordination was a Scaled Score of 6.

Academically, Billy shows strengths in Arithmetic. According to the teacher he is doing average work in the classroom in arithmetic. Arithmetic Scaled Score on the WISC was 10. The Wide Range Achievement Test Grade Level was 2.6.

In the classroom, reading is the subject which Billy has the most difficulty. The Gates-McGinitie administered in the school shows Vocabulary Grade Score 1.5, and Comprehension Grade Score 1.5. The Gates-McKillop Reading Diagnostic Test showed an Oral Reading grade score of 1.8. He was unable to give letter sounds (1.7-1.9), or recognize and blend common word parts (less than 2.0). Billy earned a grade level score of 1.7-1.9 in recognizing the Visual Form of Sounds in the subtests Nonsense Words, Final Letters and Vowels. Billy needs work in Letter sounds, word blending, and word attack skills. He will probably be unable to gain in reading skills unless additional help is given. Since Billy indicates difficulty in assimilating what he hears, the R.F.U. program might be of benefit if used as a listening skill aid. The tape recorder could be used and Billy could mark his answers. The tutor could then go over the wrong answers.

Billy consistently shows difficulty with auditory memory. This shows up in the WISC and the ITPA. It is advisable to link the oral presentation with the tachistascope when work is first begun.

Since Billy presents many inconsistencies, it would be of value to investigate further possible lags in social skills. The Vineland could be used with the parents as a basis for filling in possible gaps.

Although written expression is below level, work in this area should not begin until the reading skills are improved.

Summary:

Billy shows deficits in reading, primarily. He has a poor self concept and needs success experiences, both academically and socially. It is recommended that an individual program be initiated, concentrating on reading skills mentioned. Parent counseling should be seriously considered. After

the initial academic program is begun, possible revisions will have to be made as additional strenths will undoubtedly be revealed since Eddie does not always perform consistently. The academic specialist will be in a position to consider the possibility of additional counselor help at a later date.

APPENDIX B

A List of Test Available At The Center

1. Auditory Discrimination Test (Joseph M. Wepman), Language Research Associates.

2. Ayres Space Test (Jean Ayres), Western Psychological Services

3. Basic Sight Word List (Edward W. Dolch), Garrard Publishing Co.

4. Bender Motor Gestalt Test (Lauretta Bender) American Orthopsychiatric Association, Inc. (Western Psychological Services)

5. Botel Reading Inventory (Morton Botel), Follett Publishing Co.

6. Children's Apperception Test (Leopold Bellak and Sonya Sorel Bellak), C.P.S., Inc. (The Psychological Corporation)

7. Columbia Mental Maturity Scale, Revised Edition (Burgemeister, Blum, and Lorge), Harcourt, Brace and World

8. Draw-A-Family

9. Durrel Analysis of Reading Difficulty, New Edition (Donald D. Durrell), Harcourt, Brace and World

10. Gates Advanced Primary Reading Tests (Arthur I. Gates), Bureau of Publications (Teachers College Press)

11. Gates Basic Reading Tests (Arthur I. Gates), Bureau of Publications (Teachers College Press)

12. Gates Primary Reading Tests (Arthur I. Gates), Bureau of Publications (Teachers College Press)

13. Gates McKillop Reading Diagnostic Tests (Arthur I. Gates and Anne S. McKillop), Bureau of Publications (Teachers College Press)

14. Gates MacGinitie Reading Tests (Arthur I. Gates and Walter H. MacGinitie), Teachers College Press

15. Goodenough-Harris Drawing Test (Florence L. Goodenough and Dale B. Harris), Harcourt, Brace and World

16. Gray Oral Reading Tests (William S. Gray), Bobb-Merrill Co.

17. Hiskey-Nebraska Test of Learning Aptitude (Marshall S. Hiskey), Marshall S. Hiskey, 5640 Baldwin, Lincoln, Nebraska 68507

18. House-Tree-Person Projective Technique (John N. Buck), Western Psychological Services

19. Illinois Test of Psycholinguistic Abilities (James J. McCarthy and Samuel A. Kirk), University of Illinois Press

20. Iowa Tests of Basic Skills (E. F. Lindquist, et al), Houghton Mifflin Co.

21. IPAT 8-Parallel Form Anxiety Battery (Ivan H. Scheier and Raymond B. Cattell), Institute for Personality and Ability Testing

22. Lincoln Oseretsky Motor Development Scale (William Sloan) C. H. Steolting (Western Psychological Services)

23. Los Angeles Diagnostic Tests: Fundamentals of Arithmetic (Caroline Armstrong and William W. Clark), California Test Bureau

24. Marianne Frostig Developmental Test of Visual Perception (Marianne Frostig et al), Consulting Psychologists Press

25. Memory-for-Designs Test (Francis K. Graham and Barbara S. Kendall), Psychological Test Specialists

26. Metropolitan Achievement Tests (Walter N. Durant et al), Harcourt, Brace and World

27. Michigan Pictures Test (TIP 365) Science Research Associates

28. Minnesota-Percepto Diagnostic Test (G. B. Fuller and J/T. Laird), Western Psychological Services

29. Murphy-Durrell Reading Readiness Analysis (Helen A. Murphy and Donald D. Durrell), Harcourt, Brace and World

30. Orientation (non-standardized test devised by staff members on direction, laterality, time, sequencing, etc.)

31. Peabody Picture Vocabulary Test (Lloyd M. Dunn), American Guidance Service

32. Phonics Knowledge Survey (Delores Durkin and Leonard Meshover), Bureau of Publications (Teachers College Press)

33. Pictorial Test of Intelligence (Joseph L. French), Houghton, Mifflin Co.

34. Picture Story Language Test (Helmer R. Myklebust), Grune and Stratton

35. Progressive Matricies (J. C. Raven), The Psychological Corporation

36. Purdue Perceptual-Motor Survey (Eugene G. Roach and Newell C. Kephart), Charles E. Merrill Books

37. Psychoeducational Inventory of Basic Learning Abilities (Robert E. Valett), Fearon Publishers

38. Rorschach Method of Personality Diagnosis (Bruno Klopfer and Helen H. Davidson), Harcourt, Brace and World

39. Sentence Completion (various forms)

40. Sociogram

41. Standford Arithmetic Diagnostic Test (Leslie S. Beatty, Richard Madden, and Eric F. Gardner) Harcourt, Brace and World

42. Stanford-Binet Intelligence Scale (Lew M. Termin and Maud A. Merrill), Houghton Mifflin

43. Thematic Apperception Test (Leopold Bellak), Psychological Corporation

44. Templin-Darley Screening and Diagnostic Tests of Articulation (Mildred C. Templin and Frederic L. Darley) Bureau of Educational Research and Service.

45. Torrence Tests of Creative Thinking (E. Paul Torrence), Personnel Press, Inc. (Ginn and Co.)

46. Verbal Language Development Scale (Merlin J. Mecham), American Guidance Services

47. Vineland Social Maturity Scale (Edgar A. Doll), Education Test Bureau (American Guidance Service)

48. Wechsler Adult Intelligence Scale (WAIS), (David Wechsler), Psychological Corporation

49. Wechsler Intelligence Scale for Children (WISC), (David Wechsler), Psychological Corporation

50. Wechsler Preschool and Primary Scale of Intelligence (WPPSI), (David Wechsler), Psychological Corporation

51. Wide Range Achievement Test (Joseph Jastek and Sidney Bijou), Psychological Corporation